



TODD J. MALTESE, D.O.
LAURA M. DAVIDS, M.D.

Neurology, PM&R, EMG, NCV, EEG, TCD, Sleep Medicine

650 Hawkins Avenue
Suite 7
Ronkonkoma, NY 11779
Phone: 631-737-0055
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www.mmneurology.com

WELCOME TO OUR PRACTICE! We look forward to meeting you during your first visit.

Please complete **ALL PAGES** in the attached new patient packet and bring it with you to your appointment.

- Please provide complete and accurate insurance information, and bring your insurance card and photo ID with you.
- If your condition is the result of an accident, you must provide us with all of your accident insurance information, such as No Fault or Workers' Compensation insurance carrier, date of accident, adjuster or contact phone numbers, and attorney information.
- If you have had any ***bloodwork or diagnostic tests*** (i.e., **MRI's, CT scans, EMG/Nerve conduction tests, etc.**), please bring the written report and any films/disks with you to your appointment.
- If you are transferring care from another physician, please obtain and bring your medical records and prior doctor's notes with you.
- **All copayments and/or outstanding balances are due IN FULL at the time of your visit.** We accept cash, checks, and all major credit cards. If you cannot pay your copay at the time of your visit, there will be a \$15 administrative fee added onto your bill.
- **We appreciate 24-hour notice for cancellations.** If you do not provide notice of cancellation within 24 hours prior to your scheduled visit, you will be charged **\$25** for an office visit or **\$100** for a testing visit. Thank you for your cooperation in this matter.

Prescription Medication Policy:

- Schedule your follow-up appointments to coincide with renewal of your medications.
- Controlled substances **CANNOT** be refilled by telephone.
- Any changes to medications will require an office visit.

Thank you for allowing us to be involved in your medical needs, and we look forward to seeing you soon! If you have any questions, please do not hesitate to contact our office during our regular business hours.

Sincerely,

The Staff of Dr. Todd J. Maltese and Dr. Laura M. Davids



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Last Name: _____ **First Name:** _____

Date of birth: ____ / ____ / ____ Male Female

Age: _____ **Height:** _____ **Weight:** _____

Why are you being seen in the neurology office? What are your concerns?

Primary Care Physician:

Name: _____

Address: _____

Telephone number: _____ Fax number: _____

Referring Physician (if different from Primary Care):

Name: _____

Address: _____

Telephone number: _____ Fax number: _____

MEDICATIONS Please list all of the medications that you currently take.

Medication name	Dose	Times Per Day	Medication name	Dose	Times Per Day
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

*Please use the bottom of page 2 if you need more room to list your medications.



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ALLERGIES Are you allergic to any medications? Yes No

*If yes, please list the medication and your reaction to it.

Medication name	Reaction	Medication name	Reaction
1.		4.	
2.		5.	
3.		6.	

PAST MEDICAL HISTORY Have you ever been diagnosed with or treated for the following?

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/> Cervical disc herniations
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Dementia	<input type="checkbox"/> Lumbar disc herniations
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Seizures	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Heart disease and/or stents	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> TMJ syndrome
<input type="checkbox"/> Cardiac arrhythmia and/or Afib	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Depression
<input type="checkbox"/> Gastroesophagal reflux (GERD)	<input type="checkbox"/> Tension headaches	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Attention deficit disorder
<input type="checkbox"/> Concussion/Post-concussion	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Stroke/TIA. Year? _____	<input type="checkbox"/> Cancer. What type(s)? _____	
Other medical problems:		

SURGICAL HISTORY

List all surgical procedures that you have had and their dates: _____



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SOCIAL HISTORY

Marital status: _____ Occupation: _____

Work status:

- Full time employment Retired Unemployed
 Part time employment Student Disabled

If no longer working, when was the last date that you worked? _____

Tobacco use:

- Never used tobacco products.
 Current smoker.
 Average # of packs per day: _____ # of years smoking: _____
 Former smoker.
 Quit date: _____ Average # of packs per day: _____ # of years smoked: _____

How often do you drink alcoholic beverages?

- Never Once or twice a week More than one drink per day
 Once or twice a month One drink per day Other: _____

FAMILY HISTORY Has anyone in your immediate family had the following medical conditions?

	Mother	Father	Siblings	Other
High blood pressure				
Heart disease/Heart attacks				
Diabetes				
High cholesterol				
Stroke/TIA				
Brain aneurysm/vascular disease				
Epilepsy/Seizures				
Parkinson's disease				
Dementia				
Multiple Sclerosis				
Migraines/Chronic headaches				
Tremor				
Depression/Anxiety				
Alcohol or substance abuse				
Other psychiatric illness				
Cancer/Tumors (what type?)				



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REVIEW OF SYSTEMS Check all boxes that apply to you **at this time**:

GENERAL	GASTROINTESTINAL	MUSCULOSKELETAL
<input type="checkbox"/> Fever or chills	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Joint pain
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Nausea or vomiting	<input type="checkbox"/> Muscle pain
<input type="checkbox"/> Weight loss or gain	<input type="checkbox"/> Constipation	<input type="checkbox"/> Muscle cramps
<input type="checkbox"/> Weakness	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Muscle twitching
EYES	<input type="checkbox"/> Abdominal pain	NEUROLOGIC
<input type="checkbox"/> Blurry vision	ENDOCRINE	<input type="checkbox"/> Headaches
<input type="checkbox"/> Double vision	<input type="checkbox"/> Heat intolerance	<input type="checkbox"/> Numbness/tingling
EAR/NOSE/THROAT	<input type="checkbox"/> Cold intolerance	<input type="checkbox"/> Tremor
<input type="checkbox"/> Hearing loss	BLOOD	<input type="checkbox"/> Trouble with balance
<input type="checkbox"/> Congestion/Sinusitis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Confusion
<input type="checkbox"/> Ringing in your ears	<input type="checkbox"/> Easy bruising/bleeding	<input type="checkbox"/> Dizziness/lightheadedness
CARDIOVASCULAR	URINARY	<input type="checkbox"/> Memory loss
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Urinate frequently	<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Speech difficulty
<input type="checkbox"/> Swelling of feet	SKIN	PSYCHIATRIC
RESPIRATORY	<input type="checkbox"/> Rashes	<input type="checkbox"/> Anxiety/nervousness
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Dryness	<input type="checkbox"/> Depression
<input type="checkbox"/> Cough		<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Wheezing		

DEMOGRAPHICS Please check all that apply.

Race: American Indian Asian Hawaiian or Pacific Islander
 Hispanic White Black or African American
 Other Race: _____ Refuse to Report

Ethnicity: Not Hispanic or Latino Hispanic or Latino Refuse to Report

Language: English Spanish Other: _____

PATIENT INFORMATION

Patient Name: _____ E-mail Address: _____

Street Address: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Social Security #: _____ - _____ - _____ Birth Date: ____/____/____ Age: _____ Sex: Male Female

Single Married Widowed Separated Divorced

Are you presently working: Yes No If no, date you last worked: ____/____/____

Employer at time of injury: _____

Occupation at time of injury: _____

Employer's Address: _____
(street address) (city) (state) (zip)

Employer's Phone Number: _____

Do you have an attorney? Yes No

Attorney's Name: _____ Address: _____

Attorney's Phone Number: _____

Pharmacy Name: _____ Pharmacy Phone #: _____

Pharmacy Address: _____
(street address) (city) (state) (zip)

WORKER'S COMPENSATION INSURANCE INFORMATION

Date of Accident: ____/____/____

Insurance Company Name: _____ Insurance Phone Number: _____

Insurance Company Address: _____
(street address) (city) (state) (zip)

Claim Number: _____ WCB Number: _____

Case Manager's Name: _____ Case Manager's Phone Number: _____

Please list any other physicians that you are seeing for this case (name and type of doctor): _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____
(name of insurance company)

and assign directly to Todd J. Maltese, DO, PC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

____/____/____
Date



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OFFICE POLICIES

Insurance/Referral Policy:

- It is the responsibility of the patient to ensure that his or her insurance information is up-to-date. If a claim is denied due to a change in insurance, and our office was not notified of this change prior to your office visit, you may be responsible for the cost of the entire medical bill. ALWAYS keep us updated with any changes in insurance.
- A copy of your valid insurance card must always be on file in our office.
- If your insurance company requires a referral, it is your responsibility to obtain one from your primary care physician (PCP) and bring it with you to your visit. You cannot be seen if you require a referral and you do not have one at the time of your visit.

Copay/Balance and Cancellation/No-Show Policy:

- All copayments and/or outstanding balances are due IN FULL at the time of your visit, or you might not be able to be seen. If you do not pay your copay at the time of your visit, there will be a \$15 administrative fee added onto your bill.
- We appreciate 24-hour advanced notice for cancellations. If you do not provide notice of cancellation prior to your scheduled visit, you will be charged:

\$25 for an office visit or \$100 for a testing visit

Prescription Medication Policy:

- Schedule your follow-up appointments to coincide with renewal of your medications. Please note that if needed, renewing non-controlled medications by phone may take up to 3 business days to be processed, so please plan accordingly.
- Controlled substances CANNOT be refilled by telephone.
- Any changes to medications will require an office visit.

I have read and agree to the above office policies for the practice of Todd J. Maltese, D.O., P.C.

Patient Signature

Date

Patient Name (printed)



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Health Insurance Portability and Accountability Act (HIPAA)

This consent is given to the office of Todd J. Maltese, DO, PC, to use and disclose my individually identifiable health information for the specific purposes of obtaining payment from my health plan, providing appropriate treatment, and performing permissible healthcare medical procedures.

These specific uses and disclosures are permitted under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA).

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide to such restrictions.

I have the right to revoke this consent in writing at any time, except to the extent that you have taken actions relying on this consent.

I hereby grant permission that phone calls for the purpose of confirming or canceling appointments may be made to my home phone number, and messages may be left on answering machines.

My contact for emergencies is listed below. In addition, I DO DO NOT give you permission to speak with him/her in regards to my routine healthcare matters or concerns:

 Name of emergency contact

 Phone Number

 Relationship

I consent to the above privacy practices for the office of Todd J. Maltese, D.O., P.C.

 Patient Signature

 Date

 Patient Name (printed)



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MEDICAL RECORDS RELEASE AUTHORIZATION

To: _____

Kindly release a copy of my medical records, lab reports, and/or diagnostic test results to Todd J. Maltese, D.O., P.C. I have been advised and I understand that my medical records and information are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I hereby authorize the release of the above requested medical records.

Signature

Date

Print Name

Date of Birth